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The Rights of Adult Adoptees

TO THE EDITOR: I am both a medical student and an adoptee who just last July met my biological family. Naturally I was very interested in both the July article "Adoption: Pediatric, Legislative and Social Issues"[1] and the response by Xavier Gonzalez, MD, published in October.[2] I wish to respond briefly both to the article and in particular to an issue raised by Dr. Gonzalez.

I wish first to commend Drs. Davis and Brown for a very informative *and* enlightened article. There is almost no facet of adoption that is not today either a focus of controversy or in a state of flux. Primary care physicians, by the very nature of their profession, cannot help but be affected by current adoption trends.

I especially appreciated the statements by Drs. Davis and Brown concerning the adoptee's search for his (or her) biological family. I completely agree that such searching is "a quest for information . . . [and] not an attempt to find new parents."[1] My own adoptive family upbringing was very traumatic—with a divorce, child custody battle, my adoptive mother's and sister's deaths, and much bitterness. I lacked a sense of security and well-being for most of my childhood and bore emotional scars for many years. Yet *despite* all these problems, I never once entertained the thought in my search that I would be "coming home"—so to speak—to my *real* family. I was looking for biological identity and medical information, and nothing more. My family, for better or worse, is the one that raised me, and this is the view shared by all the adoptees I have met. Emotionally it simply cannot be any other way.

I wish finally to address an issue raised by Dr. Gonzalez in his letter to the editor: the natural parents' right to anonymity. My question is this: Who really has the right—for whatever reason—to permanently deny a human being his biological identity? I doubt that advocates for absolute anonymity realize that until very recently adoption proceedings commonly did not transmit even minimal medical history information to the adoptive family. In my own case, I discovered that my grandmother has systemic lupus erythematosus and that there is a general family history of respiratory diseases. I was glad to become aware of both facts. I have also spoken with another adoptee who stopped bearing children prematurely because she could no longer withstand the uncertainty of possible genetic problems. If for no other reason, certainly the need for medical information (good or bad) is sufficient and overriding justification for direct contact with biological parents by an adult adoptee.

I personally believe that natural parents have a right to general anonymity. I do not concur, however, that they have a similar right on the basis of anonymity to permanently deny knowledge of family background, medical history and siblings to an *adult* adoptee. Once direct contact has been made, the biological parents have the right to reject a relationship (and vice versa); but to deny them the basis for that first contact, appealing to the right of anonymity, seems to me to deny the more basic right of any human being —that of knowing where one originally came from.

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More on Neurosyphilis

TO THE EDITOR: Dr. John R. Hotson's review of modern neurosyphilis[1] in the September issue was a well-organized survey of this disease. However, Dr. Hotson's criteria for diagnosing neurosyphilis cannot go unchallenged because they reflect a logical flaw in contemporary attempts to analyze the clinical profile of this illness.

It is generally accepted that a patient with a reactive serum FTA-ABS (fluorescent treponemal antibody absorption) test has had syphilis at some time. The question is, when neurologic dysfunction develops in this patient, is he a victim of neurosyphilis or of a concurrent, unrelated neurologic disease? At present we have no adequate way of distinguishing between a "modified neurosyphilitic syndrome" and a nonsyphilitic neurological illness occurring in a person with cured or latent syphilis. The investigative technique used by Dr. Hotson and others[2] of retrospectively selecting

patients with new neurologic complaints and reactive serum FTA-ABS tests is an inexact and possibly erroneous approach, leading to the inclusion of patients who once had syphilis but now have nonsyphilitic symptoms.

Unless a patient has a positive (CSF) cerebrospinal fluid-VDRL or undergoes clear clinical resolution following treatment with a decline in the VDRL titer, it is difficult to make a definite diagnosis of neurosyphilis. We applied these criteria to our case of isolated oculomotor paralysis.[3] However, as Dr. Hotson notes, the CSF-VDRL may be negative in up to 60 percent of patients and is not a reliable screening test. Other available "diagnostic" tests for neurosyphilis also have strict limitations. The CSF-FTA is a controversial procedure and its interpretation remains in doubt, making it an unsuitable test for neurosyphilis. CSF pleocytosis may be present in a variety of central nervous system disorders, such as cerebral infarction, vasculitis and multiple sclerosis. It is, therefore, of little use in diagnosing neurosyphilis, although it may be helpful in following the response to treatment. Support for a diagnosis of neurosyphilis can be gained when there is an elevation of the CSF gamma globulin above 13 percent of the total CSF protein. This occurs in 70 percent of cases. The presence of oligoclonal bands on agarose gel electrophoresis of the CSF is also helpful. But these findings do not exclude multiple sclerosis, vasculitis and chronic nonsyphilitic infections. Penicillin-induced reversal of signs and symptoms is a helpful diagnostic observation, but care must be taken not to attribute spontaneous improvement or stabilization (which often occurs in neurologic disease) to coincidental antibiotic administration. CSF pleocytosis within three weeks of penicillin treatment was used by Hooshmand and co-workers[2] and recommended by Dr. Hotson as supporting the diagnosis of neurosyphilis. Given the variability of lymphocyte counts from lumbar spinal fluid and the likelihood of spontaneous change in any meningeal process, I suggest caution in interpreting this particular guideline. Nor is the clinician's failure to identify an alternate diagnosis sufficient grounds for a diagnosis of neurosyphilis "by exclusion." In summary, no single or combined clinical or laboratory method(s) can establish with certainty the diagnosis of active neurosyphilis in most of the "modified" cases reported. In many of these reports, the diagnosis has been made by inference, based upon a serum FTA-ABS test and new neurologic signs. Hard data have been insufficient or lacking.

If, as Dr. Hotson suggests, high doses of intravenously administered penicillin is the treatment of choice for neurosyphilis, admitting the patient to hospital will be required, increasing the cost of therapy to the patient and to the medical establishment, as well as causing the patient loss of valuable time from work and family. With these issues at stake, accurate diagnosis becomes even more imperative.

In our laboratory we are exploring the use of the rabbit infectivity test to diagnose neurosyphilis. This is an unambiguous, highly specific technique for recovering pathogenic *Treponema pallidum* from body tissue. Using spinal fluid from patients with suspected neurosyphilis, we have resurrected this method from the preantibiotic era and modified it to make it highly sensitive and clinically applicable.[4] Time will tell if this approach will help us break through the circular reasoning that has so far impeded analysis of the serological and clinical profile of modern neurosyphilis.

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The First Devil of Nutrition Cultism

TO THE EDITOR: We appreciate the journal's publication of Dr. Victor Herbert's good article on nutritional cultism.[1] Especially interesting was his labeling Satan as the first nutritional cultist; this helps connect religion and medicine at their roots. Since Indian philosophy says God and time are the same, long-term scientific observations may be more sacred than we suspect.

Indeed, God (time) has been thought to speak to man in three ways: (1) *scripture,* (2) *nature,* (3) the *divine imprint* on man.[2] Let us use these tools to see if we can tentatively identify "the apple" Eve ate and then gave Adam.

First, *scripture* (cultural fossils from early man's observation of nature) says this apple was so important that it caused man's fall from health to illness.[3] Second, scripture gives statements that may